Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS RADIOLOGY
C/O DOUGLAS G KRAUS
8401 DATAPOINT STE 600
SAN ANTONIO, TX 78229

[redacted]

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-11-4837

MFDR Date Received
August 17, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are appealing the charge denied because our doctor is not an authorized HCN provider."

Requestor's Position Summary dated March 20, 2013: "South Texas Radiology Imaging Centers is not a network provider for any of the three networks listed in these MDRs, however, we are aware that under §1305.006 a network is liable for the health care provided to an injured employee pursuant to a referral, approved by the network, from the injured employee's treating doctor … We were informed that if the network denied our RFR that the appropriate next step would be to file an MDR with TDI who would not only be able to receive verification that the out of network care was not authorized but would also have the authority to verify that the employee was appropriately notified by their employer of the requirement to see only network providers … We are seeking a decision by TDI, via MDR"

Amount in Dispute: $93.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The billed charges for 09/08/10 were denied as out of network provider. The provider is quoting Insurance Code 1305.006…We do not show that the Network has approved out of network care of this claimant therefore, our position remains the same."

Response Submitted by: Liberty Mutual, 2875 Browns Ridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
September 8, 2010	72114	$93.82	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X397 Provider is not within the Liberty Health Care Network (HCN) for this customer. Tx Insurance Code 1305.004 (B) and Labor Code 401.011

Issues

1. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307?
2. Is the requestor entitled to reimbursement?

Findings

1. The parties in this medical fee dispute are in agreement that the health care provider that provided the service in dispute is not contracted with the Liberty Health Care Network (HCN). On March 4, 2013, the requestor was notified via letter that the complaint process outlined in Texas Insurance Code Subchapter I, §1305.401 - §1305.405 is the appropriate administrative remedy to address matters related to health care certified networks. The requestor responded to the division on March 20, 2013 seeking a decision from the division's medical fee dispute resolution section. "

   The requestor seeks a decision from the division's medical fee dispute resolution (MFDR) section. The authority for MFDR to resolve matters involving employees enrolled in a health care certified network is conditional. The condition is described in 28 Texas Administrative Code §133.307. Applicable §133.307, 33 TexReg 3954, effective for disputes received on or after May 25, 2008, under paragraph (a) (1) states that "This section applies to a request for medical fee dispute resolution for non-network or **certain authorized out-of-network health care** [emphasis added]…" That is, the division's medical fee dispute resolution section may address disputes involving health care provided to an employee enrolled in an HCN only if the out-of-network health care provider was authorized to do so.

   The requestor in this dispute has the burden to prove that the services were authorized out-of-network care and thereby eligible for resolution pursuant to §133.307. The requestor in position statement explains "Often we provide services to an injured employee and have not been provided any documentation to indicate that the employee is under the care of a certified network much less that out of network care has been authorized. We do, however, assume that this is what has occurred in the absence of any documentation to the contrary (out of network referral)." The requestor's presumption does not satisfy the burden to prove that the services in dispute were "authorized out-of-network health care" required for review under §133.307. The division concludes that the services in dispute are not eligible for review pursuant to 28 Texas Administrative Code §133.307.

   Furthermore, the Texas Department of Insurance ("TDI") rules at 28 Texas Administrative Code sections 10.120 through 10.122 address the submission of a complaint by a health care provider, to a workers' compensation health care network ("network"). If the health care provider is dissatisfied with the resolution of such complaint, then it may submit a complaint to TDI. The Requestor in this dispute did not document the filing of such a compliant, or any finding by either the network or TDI as a result of a compliant, that the network had authorized any referral to the requestor for the services provided in this dispute.

2. Out-of-network health care is defined at Insurance Code Chapter 1305, section 1305.006 titled Insurance Carrier Liability for Out-of-Network Health Care. No documentation was found to support that the health care in dispute is authorized, out-of-network health care pursuant to Insurance Code Chapter 1305. This dispute may **not** be resolved pursuant to 28 Texas Administrative Code §133.307; for that reason, no additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

[redacted]	[redacted]	April 11, 2013
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.